Clear Form

PREMERA BLUE CROSS

P.O. Box 91120, MS 295
Seattle, WA 98111-9220

B

Group Medicare Supplement Enrollment Application
Washington State Health Care Authority

You can become a Washington State Health Care Authority Medicare Supplement member if you:

- Are eligible for the group's Medicare supplement plan
- Currently have both Medicare Part A and Part B, **and**
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

For Office Use Only
Group Number:
_____
Effective Date of Coverage:
_____ / _____ / _____
Enrollee Class (if applicable):
_____

Please PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted. PLEASE RETURN ALL THE PAGES OF THE APPLICATION EVEN IF THEY ARE BLANK.

A Your Information

Applicant

I am eligible for Medicare Part A and B because: ☐ Age 65+ ☐ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Last Name	First Name	Middle Initial	Social Security Number (required)		
Home Address (cannot be a P.O. Box)		City	County	State	ZIP
Mailing Address (if different from above)		City	County	State	ZIP
Daytime Phone Number ( )		Email Address			
Birthdate *Month*	*Day*	*Year*	Gender ☐ Male ☐ Female		

Dependent

I am eligible for Medicare Part A and B because: ☐ Age 65+ ☐ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Relationship to Applicant: _____

Last Name	First Name	Middle Initial	Social Security Number (required)		
Home Address (cannot be a P.O. Box)		City	County	State	ZIP
Mailing Address (if different from above)		City	County	State	ZIP
Daytime Phone Number ( )		Email Address			
Birthdate *Month*	*Day*	*Year*	Gender ☐ Male ☐ Female		

B What Plan Do You Want?

Which Medicare supplement plan do you want to enroll in? ☒ Plan F

Did you receive a copy of the Premera Blue Cross "Outline of Coverage"? ☐ Yes ☐ No

Did you receive a copy of Medicare's "Choosing A Medigap Policy" guide? ☐ Yes ☐ No

C Your Other Health Coverage

Please answer all the questions below as best you know how.

Applicant

Tell Us About Your Medicare Coverage (You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

b. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____

(See your Medicare card to find this date.)

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

Your Medicare Information Here

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ - ____ - _____ - ____

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	____ / 01 / _____
Part B Medical Insurance	____ / 01 / _____

Tell Us About Your Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ Yes ☐ No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)

If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐ Yes ☐ No

c. Was this your first time in this type of Medicare plan? ☐Yes ☐No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Tell Us About Your Medicare Supplement Coverage, If Any
If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave 3.b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ☐No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐Yes ☐No

Tell Us About Any Other Individual Or Group Health Insurance Coverage, If Any
If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ☐Yes ☐No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Medical Bills You Receive From Your State's Medicaid Programs
This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program?
Note To Applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. ☐Yes ☐No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐Yes ☐No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐Yes ☐No

Dependent

Tell Us About Your Medicare Coverage
(You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ☐No

b. Did you enroll in Medicare Part B in the last 6 months? ☐Yes ☐No

c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____

(See your Medicare card to find this date.)

Dependent's Medicare Information Here

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ - ____ - _____ - ____

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	____ / 01 / _____
Part B Medical Insurance	____ / 01 / _____

Tell Us About Your Dependent's Medicare Advantage Coverage, If Any
If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐Yes ☐No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)
If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐Yes ☐No

c. Was this your first time in this type of Medicare plan? ☐Yes ☐No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Tell Us About Your Dependent's Medicare Supplement Coverage, If Any
If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ☐No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐Yes ☐No

Tell Us About Any Other Dependent Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ☐Yes ☐No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Dependent's Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program?
Note To Applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. ☐Yes ☐No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐Yes ☐No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐Yes ☐No

Proceed to section D

D Conditions of Enrollment/Signatures

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true.

1. I am an eligible member of the group.
2. I have **both** Medicare Parts A and B in force today.
3. I understand that my coverage does not start until Premera accepts this application and assigns an effective date.
4. I authorize Premera, at its option, to pay doctors and other providers directly for health care I receive.
5. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
6. I also understand and agree that Premera may cancel this coverage back to its start date as if I never had coverage at all, if it is found that I have supplied false information, or any information was omitted by me or for me, on this application, and that information is material enough to affect my eligibility for coverage. (Please note: After coverage has been in force for two years, coverage may no longer be canceled for this reason.)
7. I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions. Examples are to determine my eligibility for enrollment or to pay claims. If Premera discloses my personal information for any other reason, Premera will first take out any data that can be used to easily identify me, or will get my signed permission.

Be sure to sign and date this application, include all pages of the application and provide any proof required for "yes" answers in section C, when submitting to Premera for processing.

Signature of Applicant	Today's Date
X	

Signature of Dependent	Today's Date
X	

Please Note: If you have a Medicare supplement or Medicare Advantage policy today (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete the "Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage" form.

If you have any questions, please contact your benefit department or Premera at 1-800-817-3049 or TDD for the Deaf or Hard of Hearing at 1-800-842-5357.

Important Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this plan, you become entitled to Medicaid, the benefits and subscription charges under your Medicare Supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a “Qualified Medicare Beneficiary” (QMB) or a “Specified Low-Income Medicare Beneficiary” (SLMB).
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days of losing your employer or union based group health plan.

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Who Is Eligible For Coverage?

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be an eligible retiree and enroll during one of the periods listed below:

- In the 30-day period before you become eligible for Part A and Part B of Medicare
- Within six month of initial enrollment in Medicare Part B
- Within six months of attaining age 65
- Within 60 days of retirement.
- During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, and only if you are transferring from another health plan with no lapse in coverage. Note: Existing PEBB and K-12 subscribers may change their coverage by applying for another plan offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.
- Within 63 days of losing coverage under a retiree group health plan, a Medicare Advantage plan, a health care prepayment plan, a Program of All-Inclusive Care for the Elderly, a Medicare supplement or Medicare SELECT plan, or a Medicare risk or cost plan for reasons that qualify under federal law. Your answers in section C of the application will determine if you qualify.

Dependents of Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be an otherwise eligible spouse or state-registered domestic partner of the group retiree and enroll during one of the periods listed below:

- In the 30-day period before you become eligible for Part A and Part B of Medicare
- Within six month of initial enrollment in Medicare Part B
- Within six months of attaining age 65
- At the same time as the group retiree
- During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, and only if you are transferring from another health plan with no lapse in coverage.
- Within 63 days of losing coverage as described for PEBB and K-12 retirees above. Your answers in section C of the application will determine if you qualify.

State Residents

To be eligible, you must be a current Washington State resident and enroll during one of the periods listed below:

- In the 30-day period before you become eligible for Part A and Part B of Medicare
- Within six month of initial enrollment in Medicare Part B
- Within six months of attaining age 65
- Within 60 days of retirement. Retirement date: _____
- Within 60 days of establishing Washington State residency. Residency date: _____
- Within 63 days of losing coverage as described for PEBB and K-12 retirees above. Your answers in section C of the application will determine if you qualify.